JUNE • 1949

the CHILD

HOME HELPS IN GREAT BRITAIN

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HOME HELP SERVICES in Great Britain have begun to flourish under a Government that is committed to a complete program of welfare services. But the original legislation was promulgated by a conservative Government, added to by a wartime coalition, and carried into effect largely with the assistance of a voluntary organization that received every assistance from each Government in turn. The result is that no home-help service in the world is so strongly backed by Government and local authorities. Yet we have developed a service that is anything but bureaucratic. It has the enthusiasm, ideals, and freedom characteristic of the professions that largely originated in voluntary social service.

Our beginnings were modest. Apart from isolated experiments by small voluntary societies like the Jewish Sick Room Help Society, which started one in 1895, nothing much happened until 1936, when public-health legislation, consolidating a 1918 act, gave certain local authorities, called welfare authorities, power to pay women to do domestic work for expectant and nursing mothers. (The local authorities in Britain, by the way, are county and county-borough councils and borough or urban or rural-district councils; these consist of a local elected and unpaid council. Such councils control paid permanent officials, like small editions of Parliament with its civil service.)

Each local authority concerned was to find the money required, although it was not compelled to do anything about starting a service.

The net result of this was negligible. Nearly all local attempts failed through lack of organization and failure to recruit workers. It was really nobody's business and everybody was too busy doing something else. Then the war came along and we had certain pressing matters to attend to for a few years.

Wartime, however, increased the demand for home helps. Women were needed in industry. People were becoming more tired. Hospital accommodation was overtaxed. Blitzing and a building standstill ensured that we were not going to have adequate hospital space for years to come. Home helps were more urgently needed than ever, and the Government recognized that the basis had to be broadened to cover all kinds of health cases.

A rather clumsy title, "Home and Domestic Help Schemes," was evolved in connection with fresh legislation in 1944, which indicated that help would be available under the scheme to assist in maternity cases and in cases of illness generally.

All this was very encouraging, but there just weren't any home helps to

This is the fourth of a series on home-making service that *The Child* is publishing. The first of the series, printed in August 1947, discussed the principles of this type of service. Others described the work in Finland (July 1948) and Australia (November 1948). Additional articles are planned.

subsidize, except in one or two places where small local schemes got going. It is one thing to give local authorities statutory powers; it is another to get a plan to work.

Just before the 1944 legislation was enacted, the city of Oxford Women's Voluntary Services asked the city's permission to carry out an experimental home-help scheme for, and with, the city council.

The W. V. S., which originated as a women's organization for civil defense, enrolled over a million women during the war, extending its activities to any job that needed to be done, from running canteens to acting as the distributing agency for the wonderfully generous American gifts of food and clothing.

Now in peacetime it continues its activities as a social-service organization, for it exists to help the state nationally and the local authorities locally, and it has a complete national coverage. That is, when it is at its peak mobilization, it has a representative in every street and village in the country. It is completely nonpolitical, like the British civil service, but because it is voluntary it can do a good many things in the way of experiment and improvisation that officials cannot do.

The Oxford City Council gave its blessing, and the great experiment in home helps began. There were several things to clarify. The first was the purpose of the scheme; the second, how it would function; the third, the status and conditions of the workers; and the fourth, recruitment and publicity. Right away it was decided to call the workers "home helps" and the scheme simply "the Home Help Service."

A place in the health services

The purpose was clearly to form an adjunct to the health service of the community. This ruled out all forms of what has come to be termed "private" service; that is, the ordinary domestic help which anybody might require. Owing to the shortage of domestic workers generally, there is a Government-sponsored scheme to deal with this latter problem. The National Institute of Houseworkers has been formed to improve the status of such workers and to recruit and train women who will attend, daily or hourly, any household or will even become permanent domestics to private individuals. The National Institute of Houseworkers, by the way, has managed, after much uphill work, to open nine training centers by 1949 and hopes to turn out about 700 workers this year. In 1944, however, all this was still at the paper stage.

Home helps, then, were to concentrate on *health*, with maternity cases in families with children under 5 as top priority. A medical certificate (from a doctor, a district nurse, or a hospital almoner) had to be presented by every applicant for help. It was to be an emergency service; that is, it would take only short-time cases. This excluded old people and those with chronic illnesses. It is realized, however, that when enough home helps were available, something would have to be done to help these people in their difficulties. Finally, the service was intended for any health emergency, without discrimination between the rich and the poor. Those who could pay would be expected to pay; those who could not would get the service anyway, contributing according to their means.

New career for women

As it was to be a "public" health service, it was determined that the helps, when recruited, would be the paid employees of the local authority and responsible to it, not to the householder. The householder would pay the city council and not the help. It was envisaged that a home help would visit an average of two or three houses a day, and that her work would be planned so that she was not faced with a week's washing at each house and was not kept too long in unpleasant surroundings.

In recruiting, this emphasis on a public-health service was a trump card. The home helps quickly realized that they were employees of the city, like nurses, school teachers, or policemen, and that they were visiting houses as workers in the health service and not as drudges to be bossed about. We were able to appeal to an admirable type of woman. Although very little training was possible to begin with, we soon found women who could do practically everything in the home when the mother was confined to bed. They could do housework, shopping, cooking, taking the babies out; in fact, they could take complete charge of the home. Both married and unmarried women were accepted, a small proportion on a part-time basis. The quality of the home helps resulted in an almost entire absence of complaints; on the contrary, letters of appreciation very soon became a feature.

While the administration lay in the hands of a voluntary organizer, the conditions of employment for home helps were fixed to compare favorably with those of shop and factory workers. The city guaranteed a fixed weekly wage for a 42-hour week, with overtime for Sundays and legal holidays, and with compensatory leave in certain cases. Holidays with pay were included. The support of the Ministry of Labor (employment) was obtained and employment as a home help was given a priority equal to that of factory work. This permitted women to enter this occupation with priority. (At that time all labor was controlled.)

A brochure was produced and distributed through employment exchanges, entitled "A New Career for Women." That was what we were determined to make it.

As a seal on this, the Dowager Marchioness of Reading, chairman of Women's Voluntary Services, who is well-known in the United States, offered to equip the first 40 home helps with a snappy indoor and outdoor uniform. Later schemes have adopted this excellent idea, although clothing restrictions have proved some hindrance to its universal adoption.

An office with a telephone was provided by the city. All was now set for the scheme.

The scheme was launched with a big public meeting, attended by the principal city officials, representatives of the Ministry of Health, and other distinguished visitors and speakers. At the close, *one* woman volunteered to enroll as a home help! Our first recruit! Anyhow, a start had been made and people began to talk. It was not long before we enrolled 10, 20, 30 women. In our first year about 90 women applied. Of these, 40 became

permanent workers, and a few "permanent part-time." The present strength is about twice that number.

Experience recorded in Oxford dossier

From the day when the scheme was envisaged until 2 years later, every stage reached and difficulty overcome was logged in a "dossier." This Oxford dossier was later to become the bible of hundreds of similar schemes. Problems included cost to patient; allocation of administrative costs; saturation point of recruitment; and the welfare, training, and so forth, of the home helps.

In the first year's working of the service in Oxford, home helps were provided for over 1,000 families (the population of Oxford is about 80,000). All classes used the service: University dons (professors, and so on), workers from the great Nuffield motor works; people in the few slums that still exist. The social implications of the scheme became plain.

For one thing, hospital accommodation in England is overcrowded, but a great amount of "out-patient" treatment is frustrated because the patient cannot rest and get someone to run her house. No official estimates have been made, but it is a good guess that the cost of home helps to local authorities and to the Ministry of Health, through assessment, has been partly saved in hospitalization costs.

Again, it was found that by adding home help to the other home-care services—that is, district nurses, health visitors, midwives—a great strain was taken off married couples. With this strain removed, couples were less likely to separate if illness struck the home, or if quarrels arose when an ailing housewife was unable to do her household duties properly.

The preventive side of home help had been apparent from the first. It is, of course, far better to keep people from becoming ill than to patch them up afterwards. So, whenever possible, we stepped in before things got too bad.

We also found that in poorer homes the home help was often able to advise the housewife on how to improve her management. Incidentally, if a house was too dirty, two home helps were sent to attack the job thoroughly at the start.

This "home help" will stay until the mother is again able to attend to her household duties.

Home helps save the day

The following are some of the kinds of situations in which a home help was used.

1. A mother, with two children aged 5 and 2, who was threatened with miscarriage each month during pregnancy, received help for 4 months. The doctor, as well as both parents, testified that she would probably not have carried her baby successfully without the service.

2. A doctor wrote that his patient could leave the hospital on a certain date "only if you can supply her with a home help."

3. A husband telephoned to say his wife was returning from the hospital with twins. The family would be satisfied with 3 hours of help daily.

4. A mother with three other children, having a baby at home, needed meals prepared for the children and two adults.

5. An old lady of 90, living alone, had broken her leg. Help was needed especially in early mornings to light the fire, prepare breakfast, and so on.

6. A professional woman, living alone, having had a minor operation, wanted a few hours' daily help for about a fortnight.

7. Mother with first baby, soon returning from the hospital. Husband wanted the flat cleaned up before her return, and then 2 hours' help daily.

8. Health visitor reported that a mother of six children was losing interest in looking after her home as a result of ill health and overstrain. Could help be sent until the woman becomes stronger and regains her normal outlook?

9. Hospital almoner on the telephone: If we can supply home help to a patient convalescing from appendicitis operation, she can be sent home immediately.

For training of home helps

At that time very little training of home helps was possible, but we arranged demonstrations, lectures, and talks. We were later able to negotiate with the National Institute of Houseworkers, which now accepts working home helps for examination for the diploma.

Out of the first batch of diplomas awarded by the institute, 21 went to home helps.

The majority of home helps will ultimately qualify for this diploma, which is of high standard and carries certain wage guarantees. This will ensure that the whole service is trained to a high standard.

Organizer is keystone

In 1946 the Ministry of Health examined such home-help schemes as then existed throughout the country and recommended the Oxford scheme, along with that of a London borough, as a model for all local authorities. The Ministry also incorporated our finding

that the success of a scheme depended on appointing a full-time paid organizer, who should be a good administrator, an enthusiastic recruiter, and a sympathetic person. The organizer, besides running a scheme day-to-day, would have to estimate the amount of help to be allotted to each family, and also to interview the "patient"; and she may have to perform the delicate task of assessing those who ask for reduced terms. This assessing is carried out according to rules laid down by each local authority.

At the same time, London headquarters of Women's Voluntary Services set up a home-help department to aid in the expansion of the service on a national scale. For the next 2 years, using the network of W. V. S., meetings were held up and down the country to pass on to local authorities the knowledge gained from the Oxford experience and to give publicity to the scheme.

Rural areas especially need home helps

It is interesting to note that home helps were first established successfully in towns. At one time it was thought there was not the same need in rural areas. Experience is beginning to prove, however, that the need may be even greater in scattered rural districts. Whereas at this stage one home help per thousand population may be adequate for a town, the ratio of home helps to the population may need to be higher in country districts.

In a survey of the development of the home-help service in five neighboring counties, two interesting facts emerge:

1. Decentralization of the service to the smallest possible unit of the community, particularly to the village, is essential to the smooth and adequate running of the scheme.

2. Despite the fact that decentralization is or will be general in each of the five counties, the *pattern* of administration varies.

Generally speaking, most counties develop their scheme piecemeal—first in one town and then in another—and gradually include the surrounding districts. By this means a few counties were able to report complete coverage by July 1948.

Recently, a bold experiment in Somerset proved successful. The county council decided to set up a complete service simultaneously throughout the whole country, using Women's Voluntary Services with its decentralized framework for purposes of organization. Within 6 months a country-wide service was established and in operation, with 273 home helps working. This was achieved with the help of Women's Institutes, and of members of W. V. S. in the villages, and in collaboration with district nurses.

The difference in cost between a county scheme in which all administrative overheads are borne by the county council and where one voluntary aid is used to the full, can be enormous. Each county council decides, however, whether or not it will use voluntary help.

Valuable indeed is the "home help" who can get along with the children of the household.

How organizers were trained

The next problem to be tackled, as had been foreseen, was the training of organizers. Local authorities were offering good remuneration to home-help organizers, but of course no specialized training yet existed. Already candidates were being sent to gain experience in model schemes, but something further was required. In conjunction with the Ministry of Health, Women's Voluntary Services began residential training courses for women who wanted to specialize as home-help organizers or who were taking up duties with local authorities. The background of knowledge and understanding had to be assumed—in whatever field this might previously have been—and specialized training on the organization and administration of a home-help service concentrated into 1 week, with follow-ups at model centers, refresher courses, and correspondence.

These schools, which are both exhausting and exhilarating, are held four times a year and are addressed by

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MENTAL WINDOWS FOR HOSPITALIZED CHILDREN

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AT BELLEVUE HOSPITAL, New York City, in a classroom for orthopedically handicapped children, a large low table holds a number of objects to illustrate story-lessons. Children just learning to read and write paste cardboard houses, model clay animals, make a pool to hold water, spray "snow" on paper trees to bring "winter." This waist-high table, with its world in miniature, expands the minds of small patients to conceive of the world outside. Many of them have known little beyond the hospital walls. It is significant that their favorite bunny in a frieze painted around the walls for Easter is pictured on crutches.

All hospitalized children, whether they are 2 years old or in their teens, need wide mental windows through which to view the world. The restraints and deprivations imposed on a child undergoing treatment must be offset by educational opportunities in the hospital which provide experiences for growth and development. Often the handicapped child is socially immature because he has come from a too-protected environment; or because he has never had the normal life of a child; or because he has been a misfit among other children. A well-rounded program of instruction, guidance, and recreation will develop his self-respect and capacity for adjusting when the time comes to go home.

No matter how severe his handicap, every child profits when he is introduced to group teaching. For example, less than 2 years ago, a 17-year-old—let's call him Jack—who is now happily attending regular high school in a wheel chair, was carried, a helpless cripple, into Bergen Pines (N. J.) Hospital for treatment. He was one of the "old" polio cases uncovered by the Bergen County Tuberculosis Association.

Disabled in his back, legs, and arms, Jack had been home-bound from the age of 4. He had had lessons from a home teacher, but no other outside companionship. When he entered the hospital, he seemed a hopeless bit of human wreckage, obesity adding to the impression he gave of low mentality. Nevertheless, it was decided to place him in the high-school class in the hospital, where he could stay all day.

At first, Jack was silent, withdrawn, expressionless. Then with understanding encouragement from the teacher and other members of the hospital staff, he began to emerge from his shell, and to respond, awkwardly at first, to praise and attention. Especially, with the companionship of other young patients, he developed a whole new language of expression. It was discovered that he was a good student with a will to learn and that his hands, which had been as inert as the rest of his body, had unsuspected skill and strength. He was put to work making models and lettering freehand maps to illustrate history lessons. Physical therapy and medical treatment improved Jack's health, but the social climate of the hospital class had equal therapeutic value in restoring him.

Another member of the class presented other problems for the teacher. A 15-year-old—we'll call her Betty—had polio when she was 7, necessitating a series of operations which kept her from attending regular school. Betty was a superior student, and there was no problem of "bringing her out"; but she had not learned to live with people. Determination to overcome handicaps made her intolerant and demanding and easily annoyed when she was crossed. With skillful handling by the teacher, her aggressiveness was directed into leadership activities, and the self-respect she gained encouraged her to improve her untidy apearance and unattractive personal habits. Betty is now a senior in high school, planning to be a secretary. When she came back to visit the hospital recently, she was an attractive, well-groomed, and poised young lady on crutches.

Many hospitals neglect child's education

These few examples demonstrate what can be done in the hospital for boys and girls—from small children in the impressionable years to young people going through the troubling years of adolescence. Yet in many hospitals even children of school age receive no organized education, in spite of the fact that most physicians recognize the therapeutic value of education as part of total care.

Our public-school system, which is responsible for providing education for all children, is also responsible for seeing that school comes to the child wherever he is. The objectives are not fulfilled, however, by giving a child only an hour or two a day of bedside tutoring, as is often done. The whole day must be considered, for the hospitalized child cannot run out to play after school hours or on week ends, nor can he always go home for holidays.

There are obvious advantages when a hospital school is connected with a board of education. It enables the board to set up a program, to assign qualified teachers, and to establish criteria for continued evaluation of the work. But neither the teacher nor the pupil should be confined rigidly to textbook lessons. There must be time and

Readers who are interested in learning more about opportunities for education for children in hospitals may be interested in the booklet, "Advancing the Education of the Hospitalized Child," the report of a conference held in Atlantic City, N. J., February 1948. Write for copies to the National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y. (Publication No. 72.)

New experiences come to these little hospitalized children through the characters in books.

opportunity to interpret learning in terms of living and for the interplay of group work.

Lack of such interplay is illustrated by the conditions in one orthopedic ward for teen-age girls, where the teacher goes from bed to bed listening to lessons. Propped up in various positions, her pupils write in their notebooks, with the one idea of keeping up with their grades. Much of the teacher's time is taken up with the red tape of public-school forms and reports. There is no give and take in this group; no visual material that all can share; no exchange of thoughts and opinions. It is a sterile atmosphere, and the girls do not look happy.

Quite a different situation exists at Goldwater Memorial Hospital on New York City's Welfare Island, where two trained and ingenious teachers manage to create a living experience for children too handicapped to return to normal life. Here boys and girls from 9 to 19, with varying disabilities, are wheeled into a large, airy room that looks across the water toward Manhattan. These ill children are grouped in the classroom, not always according to age, but according to their progress and learning ability. Each child presents a different problem for the teacher's help and encouragement. The children come together both morning and afternoon; and the program includes songs, storytelling, games, and films, as well as making puppets, decorations, and other things for group projects. Whatever his disability, each child is given a chance to participate. A boy too ill with a heart condition to do anything but observe is brought into this happy atmosphere to relieve him from the monotony of the wards.

Teacher brings the outside world to the child

Occasionally the Welfare Island teachers go out with pupils who are able to make field trips. For the others everything that is talked about must be explained and pictured—animals, a grocery store, trains, ships, machines. It takes imagination to fill the vacuities in the mind of a child who has known none of these things.

At Sunny View, Eastern New York Orthopedic Hospital, in Schenectady, teachers appreciate the delight children take in growing things. Patients have individual flowerpots to tend—plants which are their very own to watch and be responsible for. Beans are planted so that the children can observe germination. The group is divided into committees, according to the species they plant. Everyone helped when an indoor wildflower garden was developed. Visitors from the community brought plants, and the plumber made a huge pan for them from sheets of galvanized tin.

Elementary experiments in science bring great joy to children at Sunny View. So that bed patients may participate, the beds are protected with old sheets, and the youngsters are given trays to work on. With dry cells and wire the children make electromagnets, magnetize objects, test them at intervals, and keep a record of how long the magnetism lasts. Barometer cloth, soaked in a solution of cobalt chloride, is made into dolls and flags so that pupils may have the fun of forecasting the weather.

Mental and social progress must match or even exceed physical improvement if a child is to be in a true sense rehabilitated. This cannot be accomplished when little patients are left for long hours to their own devices. The preschool child particularly has been denied guidance and attention in hospitals. Confined to his crib like a prisoner behind bars, his only outlet lies

in toys that often are not carefully selected for their educational value. He attracts attention by throwing or destroying whatever he can get his hands on. Bad habits and frustration are the result, at a time when he should be learning good social habits.

At University Hospital, Ann Arbor, Mich., a whole-day program is carried out for children from 15 months of age to the high-school years, and is maintained 6 days a week for the 12 months of the year. The program is planned to fulfill the needs of the whole child, and it is set up around hospital routines and the medical schedule for each child's particular case.

No matter how severe his handicap, every hospitalized child can profit from group teaching.

For more social contacts with other children

To quote Mrs. Mildred H. Walton, supervising teacher, "The basic needs of an ill child are much the same as those of well children, except for some additional ones and more emphasis on specific ones. To combat the isolation that illness inflicts, the hospitalized child needs to do as many of the same things in the hospital as he would be doing at home or in a home school. He needs social contacts with other children and contact with the outside world. He has the usual emotional needs, with special need for reassurance, security, and freedom from fear."

At University Hospital there is a schoolroom, a workshop, and outdoor space on the roof. The daily program begins with a short play period. This period gives teachers a chance to help children needing social adjustment, to help retarded children in selecting and using toys, and to help restless children increase their span of attention by teaching them how to get maximum use out of toys and materials.

After the period of free play, the school program occupies the rest of the morning. Primary-grade children gather in front of the blackboard. They sit around a large low table, and those in beds or in wheelchairs are near by. Older boys and girls go to schoolrooms on another floor. Preschool children remain on the roof with their toys, as they are more happily situated there than in the wards.

At 11 o'clock all the children are returned to the wards for lunch and naps and at 2 o'clock they are brought back to the roof, to stay until 4. Boys and girls between the ages of 8 and 14 go to the craftshop if they wish, but this is entirely the child's choice. The first part of the afternoon is occupied with child-initiated activity, with the teacher encouraging group play. In the latter half of the afternoon the whole group, regardless of age, participates in some group project. This may be storytelling, a motion-picture film, music, dress-up play, or finger painting.

Student teachers from the University of Michigan School of Education give 6 hours a week to the hospital school. Under nine regular teachers, the students, through practice and observation, are oriented in the philosophy of teaching the handicapped. At weekly meetings, the education staff reviews the program together, shares experiences, and discusses techniques.

To be certified as qualified for this kind of teaching, requires, in Michigan, a minimum of 30 semester hours in special education courses. Teachers assigned to the hospital without special training are given temporary certification, based on their agreement to take 6 semester hours a year to fulfill the requirements.

Student nurses are also brought into the program by being relieved of their duties for a week to study under the supervising teacher. Toy cupboards, which nurses can draw from, are kept in each ward, stocked with educational and instructive toys for children of all ages.

A weekly meeting is held, attended by the education staff, occupational therapists, the librarian, and members of the social-service department. In the discussions of this group, plans are made for occupying the children's time while the teachers are off duty.

To carry out a successful program of hospital education, every member of the hospital staff must appreciate its importance in the plan for total care. This implies teamwork on the part of physicians, nurses, therapists, and, in fact, of everyone who comes in contact with the child. It is in his daily relationships with all these people that the child grows and develops. With the cooperation of the hospital administrator, the nursing supervisor, and others, treatment routines can be arranged so as to allow adequate time for a consistent education program and adequate space to carry it out. Granted, there is often a shortage of personnel and a natural tendency to obstruct

change; but with planning and a desire for and recognition of the need, the child's treatment, education, and recreation can be incorporated into an all-day program that allows him to live a more normal life. This entails utilizing available personnel to the best advantage.

Teacher should be recognized as part of team

Too often the school teacher is excluded from the hospital team and relegated to an extraneous position. She is accepted neither professionally nor socially as a bona fide member of the hospital staff. Her program suffers when she must "catch as catch can" to get enough time with her patients and enough facilities with which to work. Such a position, frequently underpaid, is not attractive to competent teachers.

Yet in institutions where the teacher's special contribution is recognized, she is often called on for valuable services beyond the call of duty. At University Hospital a little girl in a complicated apparatus was tearing her bandages in a state of emotional disturbance. A teacher who was called upon to help with the case interested her in doing something to occupy her mind and hands. Under the teacher's influence, the child became quiet and more content. At the Sigma Gamma Hospital, near Mt. Clemens, Mich., the teacher is informed when a child is to undergo special treatment or surgery. She discusses it with the children in the group, and the patient who is to have this treatment is helped to understand and to accept it. This helps to take away the frightened, hurt look in a child's eyes after he has undergone an operation.

To review principles of child development

It has been suggested that in-service training in the field of child development for all hospital workers might raise present standards. An orientation program, starting with basic principles and assumptions, would point nurses, social workers, teachers, and others in the same direction. Very few institutions have this correlation, although the principles are taught in professional schools for nurses, teachers, doctors, and social workers. What is lacking is a review and reemphasis of this training when the worker joins the staff of a hospital. Regular staff meetings, where all workers come together, are especially recommended.

As new hospitals are planned and built, provision for educational facilities should be kept in mind. In existing institutions, when space becomes tight and schedules crowded, the education program usually suffers.

Encouraged by a high-school teacher, these handicapped youngsters are having a lively discussion of current events. This helps to keep them in touch with the world outside.

War conditions hit hospital education

In one New York hospital, before the war, the whole top floor was given over to the teacher and her pupils, with excellent provision of space, light, and air. Under today's regime, the schoolroom has been reduced to a small, crowded area, with poor lighting and lack of storage space.

New hospitals should be planned to include a classroom, supply closets, and storage facilities near the wards. The room should be large enough to accommodate a group of children in beds, wheelchairs, or carts, and it should be well-lighted and attractively arranged. There should be enough space in wards for group work also. In a small hospital, where children who are long-term patients are few and far between, classroom space, when not needed for children, could be adapted to other uses—for adult patients' use, nurses' classes, or conferences. The important thing is to have the space available for children when they need it.

Although data on the number of disabled children in hospitals are incomplete, there is sufficient information to conclude that these children's needs are tremendous. Every day in the year there are some 3,300 patients in children's hospitals; 4,300 more in orthopedic institutions; and thousands more in general hospitals.

A survey within the past 5 years made by the Children's Bureau of the Federal Security Agency reports more than 341,000 crippled (badly handicapped) children in the United States. Infantile paralysis stands at the head of the list of causes, with more than 62,000 young patients. Cerebral palsy is next with more than 33,000. When we remember that in 1946, 1947, and 1948 there were approximately 64,450 new cases of infantile paralysis reported in the United States, we realize that children recovering from this disease remain one of our greatest obligations.

Community leaders can help a great deal in building a happy future for orthopedically handicapped children, especially in education, which is a vital part of therapy. First, local groups must find out how many such children there are in an area and what conditions prevail as to their care and education.

Volunteers in the hospital and board

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TOWARD BETTER HEALTH FOR EVERY CHILD

American Academy of Pediatrics Reports to the Nation

ELDREDGE HILLER

NOW THAT the American Academy of Pediatrics has completed its 3-year Nation-wide study of child-health services, we know much more about what health services are available to the children in the 3,000 counties of the United States. And health planners can use this information as a base for positive and constructive action toward the goal of better health for every child.

Summary of findings available

The study was made with the help of the Public Health Service and the Children's Bureau, both of the Federal Security Agency. Substantial aid was given by the National Foundation for Infantile Paralysis; the National Institute of Health, Public Health Service, Federal Security Agency; the Field Foundation; and many leading commercial houses. The findings have been summarized in a report, Child Health Services and Pediatric Education, published by the Commonwealth Fund, New York City. A second volume is to be issued soon, giving the methods used in the study and basic tables from which the summary report was written.

The two-volume report represents the most comprehensive inventory of health services ever undertaken. It includes information from most of the practicing doctors in the United States; from all of the 6,000 hospitals that admit children; and from official and voluntary community health agencies. Also, since a study of child care must involve an evaluation of the training of the doctors who give the care, it reports the results of personal visits to each of the 70 approved medical schools in this country and all their affiliated teaching hospitals.

The general practitioner is the bulwark of child care

A startling result of the Nation-wide inventory comes from the answers of the physicians who have child patients—and most physicians do treat children. According to doctors themselves all too many gain their first real experience in the care of children *after* they enter practice. There should have been more opportunity for them to have such experience while in medical school and hospital internship. As it is, they get their training the hard way—from experience and from postgraduate courses and clinic work.

The problem of physician training for child care is directly traceable to the financial crisis in medical schools. High standards of medical education are being threatened by lack of funds for teaching budgets and by the resulting inability of schools to attract and hold the teachers who are needed to give the requisite clinical training.

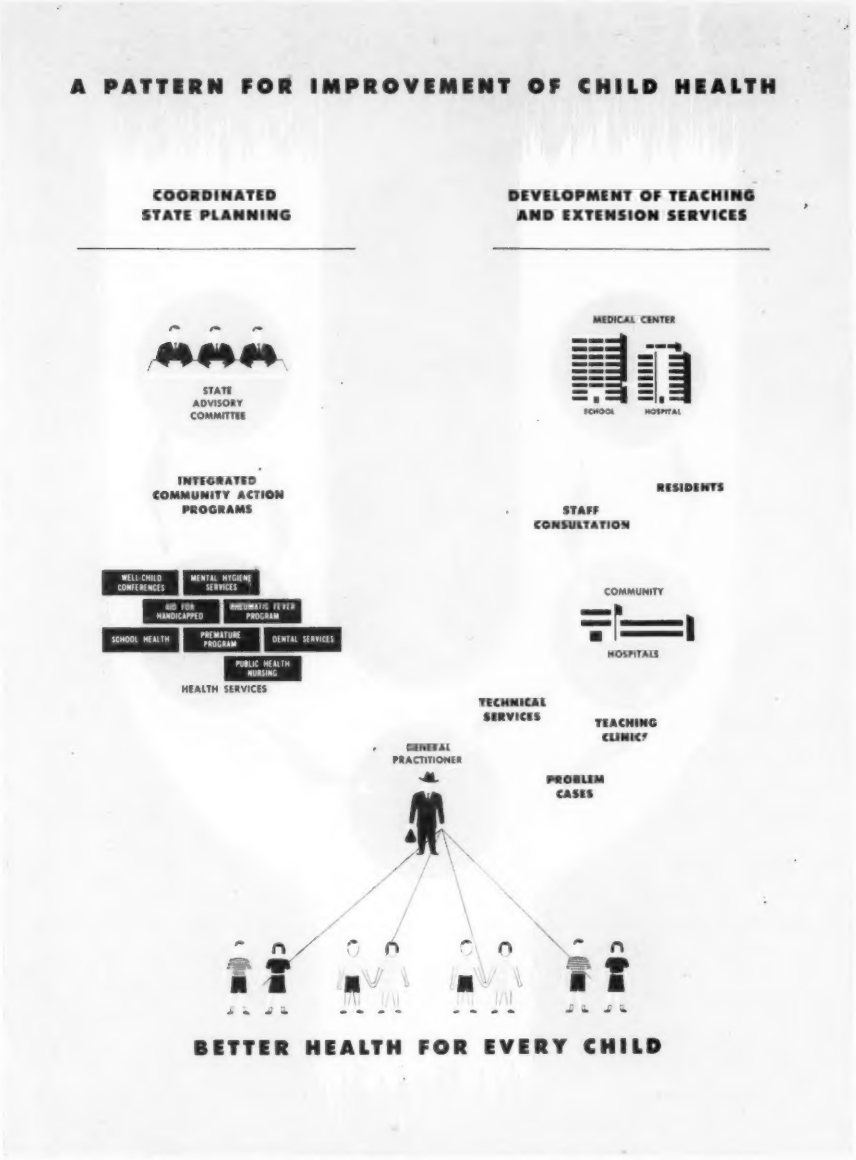
It is the undergraduate clinical teaching in hospital wards and outpatient departments that fixes in the medical student's mind the practical use of his classroom knowledge. This knowledge must be strengthened by providing him with more clinical teaching hours. That means more money to recompense teachers so that they can afford to take more time away from their private practice to teach.

The survey of medical schools shows that, although a few schools provide as many as 300 hours of clinical teaching in pediatrics for undergraduates, the average is only 161. And some schools provide less than 50 hours, which means that students are graduated from these schools having received less than 50 hours of actual contact with child patients in wards and out-patient clinics.

But when he receives his M. D. degree, the medical student is only beginning his practical training in child care. A period of well-rounded *graduate* training in a hospital, in which the doctor-patient relationship is established under faculty supervision, is essential preparation for good medical practice. Interns and residents, with the guidance they receive from experienced physicians, acquire sureness in applying their theoretical learning to actual child problems before they are thrust entirely on their own. Many students, however, cannot afford to acquire special hospital training. Financial aid in the form of fellowships must be increased to allow more physicians to round out their training as hospital interns and residents.

Family doctor needs pediatric training

The doctor who plays the greatest role in the care of the Nation's children, the study shows, is the general practitioner. Three-quarters of the private medical care of children in this country is in his hands. Of the Nation's 116,000 practicing physicians, two-



With the results of the Academy's local studies as a basis, State advisory committees are making plans suited to the needs of their individual States. All have the same objective: To make good medical care available to every child, regardless of who he is or where he lives.

thirds are general practitioners. And it is the family doctor who braves the rigors of country practice. Hospitals and diagnostic aid and specialists are few and far away. He must depend largely on his own judgment, skill, and resourcefulness. Thus, the Academy holds, it is particularly important to give the student preparing for *general practice* a good pediatric education while he is in medical school and good opportunities for graduate hospital training in child care.

Once in practice, the busy family physician has little opportunity to take postgraduate courses, to catch up and keep up. It is therefore, important to extend or "beam," directly from medical centers, the postgraduate training and special diagnostic and therapeutic services that our practicing physicians, especially the remote country doctors, need and want in order to provide up-to-date child care.

In some sections of the United States plans for "decentralizing," or extending training and services from medical centers directly to isolated communities, are being developed by philanthropic foundations, State and county medical societies, and medical schools. Where the programs are in effect, a high quality of medicine is being brought directly to the most remote communities. The Academy's program at the national level is adapting these techniques in a demonstration program which it has just started and which it hopes will ultimately encourage heads of pediatric departments in all medical schools to disseminate their services to regions surrounding their medical centers.

Before describing that program, however, let us take a brief look at the county-by-county study which the Academy's State chairmen conducted throughout the Nation with the cooperation of public and private health and medical organizations.

County-by-county score revealed by the State studies

There is a geography of health that is linked closely with the geography of medical care, the local studies showed. In some counties where modern medical services are scarce, five times as many infants (per thousand live births) die as in more favored communities.

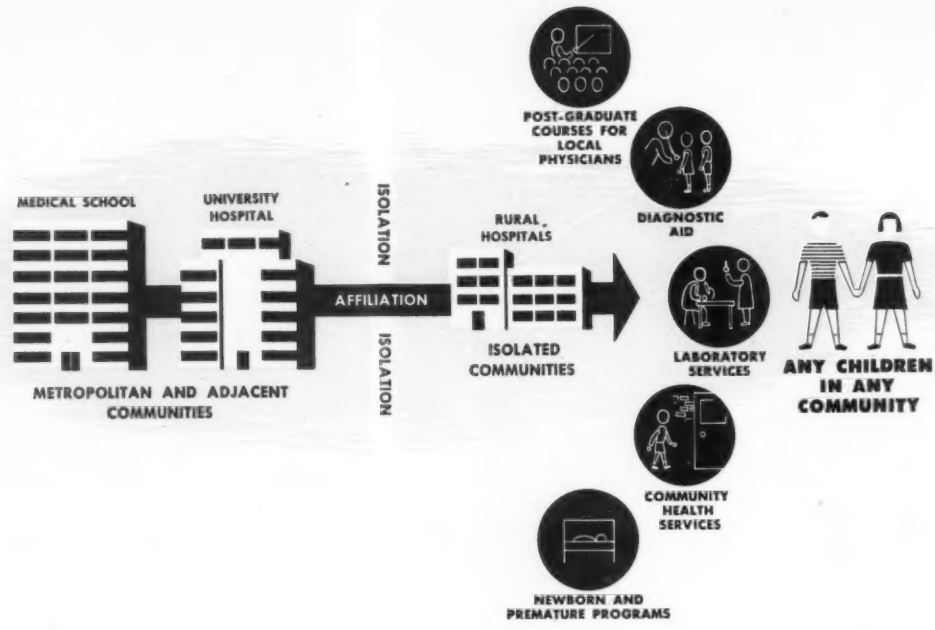
Children in or near cities receive 50 percent more care than those in isolated counties—areas to which the advantages of metropolitan areas are not readily accessible. Two-thirds of the 3,000 counties in the United States are in this category. Children in these areas particularly lack specialist care, clinic care, and the highly skilled diagnostic and treatment services that are available to their city cousins.

Hospital out-patient services are almost nonexistent outside the metropolitan counties. Some States provide over three times as much hospital care for children as others do. One State has five times as many physicians as another in relation to child population.

Community health services such as public-health nursing, clinics for physically handicapped children, well-child conferences, and premature-infant and rheumatic-fever programs are not filling the gaps left by private practice.

Two over-all needs

Therefore, if one were to distill from the entire 3-year study of child-health services the two most significant con-



When rural hospitals are affiliated with a medical center, modern medical care is available to children in isolated communities.

clusions, these would be, in informal phrase: We need to do something about the medical training of all physicians—general practitioners as well as pediatricians—to give them the best possible preparation for child care; and we need also to make it possible for children in isolated areas to have the same opportunities for good care that they have near our large medical centers.

Thus we are brought back to the original objective that prompted the study: How to make quality medicine available to all children, regardless of where they live or the income of their parents.

The study was from the outset recognized as only the first step. Now that the Academy has answered the question "What is?" there is ahead the far more difficult question, "What to do about it?" That is, how to meet the needs that have been revealed.

The Academy is not leaving future action to chance. It has created a continuing committee, aptly designated the committee for the improvement of child health. This committee, under the chairmanship of Dr. James L. Wilson of the University of Michigan, is made up of pediatricians in private practice and in academic and administrative positions. Under the executive direction of Dr. John P. Hubbard, who also directed the study, the committee has established offices in Philadelphia, and it is already well along the road on the important assignment of translating the study into positive action. Also, to dovetail the child-health program with State and county health programs, the Academy and the American Medical Association each has appointed a three-man liaison committee for cooperative planning and effort.

A twofold solution

To meet the twofold need—more training for doctors who are caring for children and a better distribution of medical care—a twofold solution has evolved. Through extension of pediatric education and services to outlying areas, fresh knowledge is brought to the hard-pressed general practitioner, and the skills and up-to-date methods of the medical centers are brought to the children in the areas where deficiencies have been shown to exist. Through creation of opportunities for graduates of medical schools to receive portions of their training as pediatric resident physicians in outlying hospitals that become affiliated with teaching centers, many advantages result simultaneously. More places are provided to train more residents and hence turn out more well-trained physicians; community hospitals benefit by the services of a resident that they would not otherwise have had; the resident himself profits from a period of very practical training; the local general practitioner is on the receiving end of a direct channel from the medical center; and the child, even in remote and isolated areas, receives better medical care and health supervision. Thus immediately we are brought closer to our goal of better health for every child.

To give practical application to this broad planning, the committee has worked out a demonstration program for decentralization of teaching and services. Stemming from a large university medical center, this program is

being developed in three Eastern States. Under this set-up, small hospitals, through affiliation with the large pediatric teaching hospital of the medical center, will be brought into close touch with metropolitan services and its modern techniques. The residents gain practical first-hand experience in the art of rural medicine, but they also serve while they learn. Their services increase the hospital's usefulness and their active participation in community health services brings forth new well-child clinics and similar health aids.

However, no over-all national program can be effective without initiative and support by the States and the communities. If children's health is to be brought up to a uniformly high level everywhere in the United States, with better health and medical services reaching into every community, State programs inspired by local medical and health organizations must be developed along with national programs.

Thus the Academy's own State chairmen are preparing State reports and detailed operating plans suited to the needs of the individual States.

The study findings have already been reported and published in Florida, Louisiana, Mississippi, Missouri, New York, North Carolina, Oregon, South Dakota, and Wisconsin. Sixteen others are in draft form.

In some States, under the auspices of the State chairmen, new committees or councils for the improvement of child health have been formed, or the representation of the existing ones has been broadened. Membership includes representatives from pediatric societies, State and local medical societies, health departments, and other organizations in the States which are active in child health and welfare.

Reports of local studies bring action

Recommendations by the State committees, based on the local study reports, are urging the expansion of many public-health programs, including the establishment of more community health services such as public-health nursing, immunization programs, mental-hygiene clinics, and aid for the physically handicapped. Recommendations involving better public-health measures have in some instances stimulated official action at the State capitals.

A tangible illustration of the value of the State findings was demonstrated in one Western State. A plan for a children's hospital had been canceled by the Governor on the ground that there was no need for it. The findings of the Academy's State study were brought to his attention, and as a result the hospital is now under construction.

Hospital administrators are acquiring constructive suggestions from these reports for improvement of their own services. But through all the State reports echoes a need for greater consideration of the trials and tribulations of the general practitioner—better training, extension of postgraduate education to him in his own community, and provision of special consultation and diagnostic aids when he is far away from cities.

The common denominator of the Academy's plan is better opportunities for all children

Reducing the idea to simple terms, the Academy says that under modern medicine your child and my child and the next child are entitled to protection of their health and to good medical care when they are sick.

That means health supervision from the time of birth in such matters as proper feeding, and immunization against diphtheria, smallpox, and whooping cough. It means continuing supervision to keep well children well during their preschool and school years. It means skilled medical attention for the sick child by a doctor who, whether specialist or family physician, is adept through training and experience at recognizing and treating childhood ailments; who can have advice from consultants on the diagnosis and treatment of difficult cases; who is versed in new drugs and therapies.

If your child and mine have these benefits, they are indeed fortunate. But until all children have them, there will continue to be youngsters growing up with defects unchecked or uncorrected, and there will continue to be many in whom diseases such as rheumatic fever gain fatal foothold for lack of early diagnosis and care.

Now for a vigorous action program at National and State levels to get good care to the *other* child.

Reprints in about 4 weeks

HOSPITALIZED CHILDREN

(Continued from page 185)

members of community agencies can lead in studying legislation and appropriations to improve conditions. Their interest can result in the appointment of well-prepared, well-adjusted teachers in this highly specialized field, at salaries adequate to attract other competent teachers to enter it.

Volunteers can also aid in supplying materials to teachers and occupational therapists; these may include special books, selected toys, wall cabinets, bedside storage cabinets, earphones for radio sets, motion-picture projectors, and films. They can promote plans for developing teaching space; for example, covering the roof, building an additional schoolroom, converting rooms already built. To keep a full-day and week-end program going, teachers can well use volunteer services in manning book carts, telling stories, and operating motion-picture projectors, as well as in other group activities.

Volunteers work under teacher's guidance

Volunteer groups have always been generous in bringing entertainment to hospitals, but *passive* looking and listening will not give children as much as *active* recreation, in which they have a chance to learn something and to express themselves. Under the guidance of the teacher, volunteers can help children create and plan plays, parties, musicales. Original work by the children is a release for their emotions and an encouragement for social growth.

The lives of hospitalized children are enriched, too, by trips to outside schools and other interesting places in the community. Volunteers can solve the problem of transportation and act as guides and attendants. To be taken to a ball game, or wheeled through a museum, or even given an ice-cream cone from the traveling ice-cream cart, means to the handicapped child being normal and, for the moment, a part of the life outside. Through these simple experiences he may be made ready for home and for companionship with other children when he leaves the hospital, without the shock of readjustment to a world which has become strange.

Reprints in about 4 weeks

HOME HELPS

(Continued from page 181)

specialists in every phase of the work. Emphasis is always on the practical problems that will meet organizers or are already facing them. An attempt is made to build up a high sense of professional vocation and to demonstrate the backing that every organizer will get.

We look to the future

In July 1948 the famous National Health Service Act came into force. This provides for a free, comprehensive health service from cradle to grave. The cost is met by taxation and to a small extent by compulsory insurance. It is a most ambitious all-round public-health service. The Minister of Health stated that home helps are an integral part of the service, and that the work of the family doctor and home nurse will be seriously hampered unless there are adequate home-help services throughout the country. This home-help service is free to those who are unable to afford to pay for it. A great many authorities already have adequate home-help services. All the rest are able to show that their plans are well-advanced. There is some years' work ahead, but there are already many thousands of home helps, and some places have reached the ideal target of one home help per thousand population.

Britain is going through many social changes; even the pattern of home life is changing. But the family ideal is not deteriorating, and there will be a great tendency in the future to strengthen the practical supports. We are building houses as fast as we can, giving them precedence over hospitals. The health authorities talk increasingly of "home care"—all the services that simplify and sustain home life, especially in times of emergency and illness. Among these services home helps are making a growing contribution, simplifying the work of doctors, preventing illness, relieving hospitals, enabling old people to live at home rather than go into group care, but still first and foremost helping mothers and children.

Reprints in about 4 weeks

• IN THE NEWS

Venezuela Publishes New Official Child-Welfare Periodical

Infancia y Adolescencia is the title of a new bimonthly periodical published in Caracas, Venezuela, by the Venezuelan Council of the Child. The Council, an official agency, is concerned with problems of child dependency and neglect.

The first number, dated January–February 1949, gives much space to day-care centers established by the Council.

Of attractive format and abundantly illustrated, the periodical is edited by Dr. J. A. Rodriguez Delgado, secretary general of the Council. A message of greeting to other child-welfare periodicals at home and abroad introduces the newcomer.

Nearly 5,000 Boys and Girls Found Illegally Employed Under FLSA

Child-labor abuses continue in many States, even after 10 years of enforcement of the Fair Labor Standards Act. This is revealed in the 1948 annual report of the Administrator of the Wage and Hour and Public Contracts Divisions, U. S. Department of Labor.

The report shows that 4,628 boys and girls under 18 years of age were found employed in violation of the act's child-labor provisions. More than three-fourths of these were 14 or 15 years of age. Forty-eight of the children were 12 years of age or younger—one was only 7. Violations of the act were disclosed in 1,384 of the 28,998 establishments covered by the act which were inspected during the fiscal year.

The FLSA sets a 16-year minimum age for most jobs, an 18-year minimum in jobs declared to be particularly hazardous, and a 14-year minimum for a limited number of specified jobs for work only outside school hours under certain conditions.

One in every six of all young persons under 18 found employed in the establishments covered by the act which were inspected was illegally employed. Child-labor violations were found in every major industry group, but the highest percentage was found in fresh-fruit and vegetable packing sheds, where three out of every four of the employed young persons were illegally employed. In sawmills and planing and plywood mills, two out of three of the employed children were under the legal age for the jobs at which they were working. One out of every two of the children who worked in laundries and dry-cleaning plants was illegally employed.

Under-age workers were found employed in 16 percent of all canneries inspected.

Summer Courses

Boston University. School of Social Work, Boston, Mass. Courses include, among other subjects, social services for children and interviewing in social work (second series, July 11–August 20).

University of Chicago. School of Social Service Administration. Chicago 37, Ill. Two 5-week summer terms, June 28–July 29 and August 1–September 3.

The sessions are planned especially for two groups of students: (1) Those working for the master's degree, who will find all basic courses and field work offered, and (2) experienced social-service workers who have this degree but wish to learn new developments in the field and broaden their professional preparation.

Field-work courses, open only to full-time professional social-service students: Basic field work, child welfare, medical social work, psychiatric social work, administration, community organization, research and statistics, and advanced family welfare.

University of Buffalo. School of Social Work. Buffalo, N. Y. Courses in case work; psychiatric social work; public welfare; family relations; and child welfare (July 5–August 27).

• FOR YOUR BOOKSHELF

YOUR CHILD'S MIND AND BODY; a practical guide for parents. Flanders Dunbar, M. D., Random House, New York, 1949. 324 pp. $2.95.

Physicians and mothers who must deal on a day-to-day basis with children often get the impression that psychia-

trists are unduly critical of usual child-rearing methods, and thus feel a need for the psychiatrists to suggest alternate and possibly better methods. In this book Dr. Dunbar fulfills part of this need. But in so doing she takes the risk of being often too positive, and of tending to lump facts and theories, presenting them all as facts.

The author is at her best in helping parents to recognize the advantages of assisting a child to learn rather than formally teaching him. She applies this principle well to the normal concern of the mother with feeding, toilet training, and sleep. In general, however, there seems to be a lack of warmth in her approach to the mother-child relationship.

The book has excellent paragraphs on the development of honesty and on the ways in which we often tend to confuse mere errors with "sin."

It includes such neat aphorisms as "Hazy parents have hazy children." Observing that "to pass on happiness you must yourself be happy," Dr. Dunbar adds, "To be happy and to give happiness are a parent's privilege and responsibility."

The blunders that parents make are well-described, but the danger of putting the burden of guilt on the child is so repeatedly mentioned that the book tends at times to become a severe criticism of parents and to leave scant room for any error on their part. Frequently it seems as though Dr. Dunbar also puts a burden on the parents by expecting from them psychological diagnosis and therapy. And many physicians will fell slighted by the manner in which she refers to their efforts in that direction (however truly these efforts may be described).

Throughout the book Dr. Dunbar has made excellent use of case histories, but her cases seem to come from a select group of intelligent children, well-supplied with nurses and governesses. She gives a curious picture of the mother—usually a working, professional person who sees her child only in the evening to discuss his daily difficulties. And the children speak in a fashion more erudite than one is accustomed to hear in daily practice.

In many ways this book seems more useful as a text for professional people than as the practical guide its title proclaims it to be. Mothers will probably prefer to stick to Spock.

Henry H. Work, M. D.

FORTY-FIVE IN THE FAMILY; the story of a home for children, by Eva Burmeister. Columbia University Press, New York, 1949. 247 pp. $3.25.

The "family" in this book are 45 boys and girls of elementary-school age who are receiving residential care at Lakeside Children's Center, Milwaukee, Wis. Miss Burmeister is the director of the center.

The fact that this is an old congregate institution makes its accomplishments stand out. It shows that lack of modern facilities does not necessarily prevent warm, friendly relationships, a comfortable environment in which children can develop, and a program that is full of meaning to children.

Although the agency centers its program on the individual child, it gives equally sympathetic understanding to the housemother. Relationships between child and housemother are emphasized, as well as the "homely, earthy, realistic duties connected with the physical aspects of child care." Recognizing that even staff members with the highest qualifications have much to learn, the institution provides for in-service training.

In the chapter, Something Smells Good, which discusses the institution kitchen and what it means to the children, the author urges that there be more giving than withholding in institutional work.

The book points out that children like, and need to have, adults play with them and that part of the housemother's responsibility is to plan and participate in the children's play. In a larger institution, or one in which housemothers are responsible for large groups of children, Miss Burmeister believes that a recreation director should be on the staff. All child-welfare workers will agree that a play program should follow the principle expressed by Miss Burmeister that "true recreation is participation, not observation."

Other chapters include such subjects as the Men in Our Lives, Bedtime, Children's Books and Reading, Bicycles, Pets, Work and Work Attitudes, the Garden, Discipline.

What case workers do is clearly set forth—intake, placement, work with relatives, direct work with children in residence. The author also takes up relations between child-care and case-work staffs.

The discussions of the personalities of children and staff alike are full of human interest, and will be enjoyed by anyone fond of children.

Own parents, as well as foster mothers and housemothers, will learn much from this book about children and successful ways of teaching them to live with others. For persons associated with an institution for children this book is "must" reading. Real pleasure is in store for all who read it.

I. Evelyn Smith

THE CHILD IN HEALTH AND DISEASE; a textbook for students and practitioners of medicine, by Clifford G. Grulee, M. D., and R. Cannon Eley, M. D. Williams & Wilkins Co., Baltimore, 1948. 1,066 pp. $12.

Seventy-five outstanding authorities in various pediatric fields have contributed sections to this textbook. A vast amount of up-to-date information on a wide range of topics, including growth and development, nutrition, the newborn, the adolescent, acute and chronic diseases, and the various body systems is concisely presented. References are given at the end of most chapters, and though not numerous they are well-selected and helpful.

The book is written as a guide for students and practitioners of medicine to help them to make practical application of the scientific advances of investigators in the lives of real children. There is variation in quality of the subject matter, as is almost necessarily true of a multi-authored book; and though there is recognition of the emotional needs of the child, the emphasis is chiefly on the physical aspects of care.

Alice D. Chenoweth, M. D.

CALENDAR

July 2–9—Second Pan American Congress of Social Work. Rio de Janeiro, Brazil.

July 4–8—National Education Association. Boston, Mass.

July 12–17—National Association for Advancement of Colored People. Los Angeles, Calif.

July 18–22—Second International Congress for the Education of Maladjusted Children. Amsterdam, Holland.

Illustrations:

Cover, Esther Bubley for Children's Bureau.

Pages 178 and 181, Pictorial Press, London, England.

Page 180, Odhams Press, Ltd. London, England.

Page 183, Charles Roland Burd for University Hospital School, University of Michigan, Ann Arbor.

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PRENATAL CARE—1949 MODEL

More than a third of a century has passed since the Children's Bureau issued its first booklet for parents, Prenatal Care. Since that first edition, this publication, like the Bureau's other bulletins for parents, has gone through a number of revisions, which have kept it up with the newest scientific thought. And in its latest edition, which has just come off the press, it has been completely rewritten.

When Prenatal Care was first published, in 1913, its chief aim was to point out and stress the need of medical care during pregnancy. And the 1949 edition makes clear that continued medical care during pregnancy is just as important as it has always been.

But today the concept of good care for mother and baby has broadened. We think more in terms of "maternity care," which includes medical supervision from early pregnancy through the birth of the baby and for several weeks later. And as in all previous editions, the new Prenatal Care sets as the goal of such care a healthy mother and baby, after a comfortable pregnancy and an easy labor.

Although the goal of maternity care remains the same through the years, some of the ways in which we strive to attain this goal have changed, and the 1949 edition of Prenatal Care reflects these changes.

For example, no earlier edition included, as the 1949 one does, a chapter telling how the baby grows before birth, with large, simple drawings to make the process clearer. In 1913 such a chapter would have shocked many readers.

Incidentally, the franker attitude of the present day toward pregnancy has brought about increased willingness of expectant parents to read books about care of the mother before the baby is born. The demand for Prenatal Care, for example, has greatly increased in recent years—much more rapidly than can be explained by the larger number of infants being born.

The new chapter on development of the embryo is one of those planned to help the mother and father understand better the physiological aspects of having a baby, but the booklet as a whole stresses more the psychological aspects. This emphasis is strong in the discussion of breast feeding and bottle feeding in relation to the emotional needs of the baby. And a whole chapter is devoted to the thoughts and feelings of the mother.

Another more modern trend reflected in the booklet is the increasing recognition of the importance of the rest of the family in relation to the baby. A chapter beginning, "When should you tell the other children about the new baby?" goes on to suggest ways in which children can be drawn into the plans for the newcomer.

"This Is a Family Affair," which might well be the title of the booklet, is the heading of a chapter written for the baby's father. This includes the words, "It is just as important for a father-to-be to read all of this bulletin as it is for his wife."

Introducing the new booklet, Oscar R. Ewing, Federal Security Administrator, says: "Doctors have known for a long time that mothers who are well-prepared for their expected babies stand the best chance of having healthy, happy ones.

"Now, more than ever before," the Administrator continues, "doctors say that being well-prepared is not only a matter of the mother's keeping physically well throughout pregnancy. Such preparation means also that both father and mother are emotionally ready and eager to welcome the arrival of their new baby.

"Here is a bulletin," Mr. Ewing goes on, "that helps both mothers and fathers to prepare for parenthood. It does not take the place of a doctor, but supports the advice and guidance he gives."

"I know of no other single element in our many-sided effort to build abounding good health in all our people," concludes Mr. Ewing, "that is more important than this one of assuring to every child the best possible start in life."

VOL. 13, No. 12 JUNE 1949

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
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SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1926, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to public officials and libraries; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is $1 a year; send remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1949